State of Rhode Island and Providence Plantations
Department of Human Services/Office of Rehabilitation Services
40 Fountain Street ~ Providence, RI 02903 ~ 401.421.7005 (V)
401.421.7016 (TDD) ~ 401.272.8090 (Spanish) ~ 401.222-3574 (Fax)
www.ors.state.ri.us

ORS Use
Region:
Area:
ORS-4 Rev. 7/03

"Assisting eligible individuals with disabilities to choose, prepare for, obtain and maintain employment."

Application & Initial Information for the Vocational Rehabilitation (VR) Program

Please fill out this application to the best of your ability. If you do not feel comfortable disclosing some of the information, you can complete the application when you meet with an ORS Counselor.

Name: _____
(Last) (First) (Middle Initial)

Address: _____ Phone: _____

City/Town:_____ Zip: _____ Alternate Phone: _____(Cell/Other)

Date of Birth: _____ Sex: ___ Veteran: Y __ N __ E-mail Address:_____

Social Security #: _____*

Have You Previously Applied for VR Services: Y __ N __ Previous Name: _____

Do you receive SSI and/or SSDI and intend to work? SSI __ SSDI __ (Attach award letter, if available.)

What is your disability?_____Unknown: _____

Are you blind or visually impaired? Y __ N __

What is your employment or career goal(s)? _____

_____

How did you learn about VR? _____

Who referred you? _____

I am applying for Vocational Rehabilitation Services because I want to work, or maintain employment if I am employed.

Signature: _____ Date: _____

Parent or Guardian (if applicable) _____ Date: _____

Do you want to register to vote? Y __ N __

In order to determine your eligibility for services and to assist you with the provision of vocational rehabilitation services to reach employment, specific information is important. Your assistance in providing the information requested on the following pages will help speed up your eligibility and employment plan process. A Vocational Rehabilitation Representative can assist you in completing the information if you wish. Please contact (401) 421-7005 (Intake) or (401) 421-7016 (TTY), if you need assistance to complete the form. En Espanol, (401) 272-8090.

(Over)

WORK & EDUCATIONAL EXPERIENCE

Work History (Most recent first or attach resume)

Employer Name and Address: ____

How did you get this job? ____

Hrs. per Week: ______ Dates Employed: ____________-____________ Gross Wages: ______________

Job Title/Skills: ____

Most Liked About Job: ____

Least Liked About Job: ____

Reason for Leaving Job: ____

* * *

Employer Name and Address: ____

How did you get this job? ____

Hrs. per Week: ______ Dates Employed: ____________-____________ Gross Wages: ______________

Job Title/Skills: ____

Most Liked About Job: ____

Least Liked About Job: ____

Reason Left: ____

* * *

Employer Name and Address: ____

How did you get this job? ____

Hrs. per Week: ______ Dates Employed: ____________-____________ Gross Wages: ______________

Job Title/Skills: ____

Most Liked About Job: ____

Least Liked About Job: ____

Reason Left: ____

* * *

Employer Name and Address: ____

How did you get this job? ____

Hrs. per Week: ______ Dates Employed: ____________-____________ Gross Wages: ______________

Job Title/Skills: ____

Most Liked About Job: ____

Least Liked About Job: ____

Reason Left: ____

Education &Training

Highest Grade Completed: _____ Special Education [IEP]: Y __ N __ 504: Y __ N __ GED: Y __ N __

Did you receive support services in school? Y __ N __ Describe (e.g. technology, aide, etc.): _____

_____

High School: _____ College: _____

Degree Obtained: _____ Year:_____

Other Training: _____

Skills/Hobbies (e.g. languages, computer skills, licenses, volunteer experience, etc.): _____

_____

INFORMATION ABOUT YOUR DISABILITY

DISABILITY/MEDICAL CONDITION (What prevents you from working?)
Describe your limitations to employment: _____

_____

_____

Medical condition (if known): _____

PHYSICIANS/HOSPITAL/CLINIC Dates of Service

Name(s) and Address: _____

_____

_____

_____

MEDICATIONS/TREATMENTS Name/Type Dosage/Frequency

_____

_____

_____

MEDICAL COVERAGE Insurance/Benefit Claim No. Provided by Employer

_____

_____

EQUIPMENT NEEDED TO WORK _____

_____

_____

COUNSELOR'S COMMENTS:_____

_____

_____

DEMOGRAPHICS

Number of Persons in Household: _____ Number of Dependents: _____

Marital Status: Single __ Married __ Widowed __ Divorced __ Separated __

Check All That Apply: White __ Black __ Asian __ Native Pacific __ American Indian __ Hispanic __

PUBLIC BENEFITS/INCOME (Optional)

(A financial needs test must be completed for many VR-purchased services. The following income information will be helpful for your initial planning.)

Cash, Savings and Other Liquid Assets $_____

GROSS INCOME	Amount (Wk./Mo./Yr.)
Wages/Salary	$_____
Social Security Insurance (SSI)	$_____
Social Security Disability Insurance (SSDI)	$_____
Family Independence Program (FIP)	$_____
Temporary Disability Insurance (TDI)	$_____
Workers Compensation	$_____
Veterans Benefits	$_____
Unemployment Benefits ____	$_____
Private Disability Insurance	$_____
Pension or Annuity	$_____
Other Income *(Savings, including spousal income, rents, interest, etc.)*	$_____

REHABILITATION EXPENSES (Non-Reimbursable)	**WEEKLY AMT.**
Medical	$_____
Rehabilitation/Adaptive Technology	$_____
Other Rehabilitation Needs	$_____

CERTIFICATION (Complete once you have met with a VR Representative)

I have been provided with an explanation of the VR program, my rights and responsibilities, and I have been given a Client Assistance Program (CAP) brochure. I have been informed that I can appeal decisions, and I have been told how to do this. I have also been advised of the necessity to have all services pre-approved by my ORS Representative and to keep him/her informed of any changes in my situation whether, medical, financial, or otherwise. I certify that the information I give is true and complete to the best of my knowledge and belief, and I know that false or misleading statements or failure to report changes may result in prosecution for intent to defraud. I understand that the information given is CONFIDENTIAL, and it will be used only for purposes directly connected with the administration of the VR program.

Signatures: _____ _____ _____

Applicant *Parent or Guardian (if applicable)* *Date*

Signature of Person who helped you complete application: _____Phone: _____

Vocational Rehabilitation Counselor: _____